Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3135AGC	A. BUILDING _____ B. WING _____	11/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PATRICK REST HOME 2	4847 NEW YORK STREET LAS VEGAS, NV 89104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments Surveyor: 28380 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 11/17/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received the grade of A. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness. The census at the time of the survey was ten. Ten resident files were reviewed and three employee files were reviewed. One discharged resident file was reviewed. The following deficiencies were identified:	Y 000		
Y 431 SS=F	449.229(2)(a)-(c) Plans for Evacuation NAC 449.229 2. A residential facility shall have a plan for the evacuation of resident in case of fire or other emergency. The plan must be: (a) Understood by all employees. (b) Posted in a common area of the facility. (c) Discussed with each resident at the time of his admission.	Y 431		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3135AGC	A. BUILDING _____ B. WING _____	11/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PATRICK REST HOME 2	4847 NEW YORK STREET LAS VEGAS, NV 89104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 431	Continued From page 1 This Regulation is not met as evidenced by: Surveyor: 28380 Based on observation on 11/17/09, the facility did not ensure that evacuation plans were properly displayed within the facility (floor plan but no exit routes indicated). Severity: 2 Scope: 3	Y 431		